EXHIBIT C

		Joseph T, M.D.	
09/07/2023	Abdominal Exploration, Evacuation Hemoperitoneum, Abdominal Packing, Temporary Abdominal Closure	Carroll, Joseph T, M.D.Gudmundsdottir, Hallbera, M.D.Bocchinfuso, Sara N, M.B., B.Ch., B.A.O.	RST ROMB OR
09/07/2023	TRANSPLANT HEART, PLACEMENT EXTRACORPOREAL MEMBRANE OXYGENATION	Villavicencio Theoduloz, Mauricio A, M.D.Chauhan, Akshay, M.B.B.S.	RST ROMB OR

DISCHARGE DISPOSITION
Expired [20]

DETAILS OF HOSPITAL STAY

REASON FOR ADMISSION
Chronic Systolic (Congestive) Heart Failure (HCC)
Pretransplant Recipient Evaluation Exam
Pulmonary Hypertension Due To Left Heart Disease (HCC)
Congestive Heart Failure (HCC)

HOSPITAL COURSE
Mr. Leopold is a pleasant 40 year old Florida CPA with a PMH of adriamycin induced cardiomyopathy who presented to the cath lab on 8/16/23 for RHC and IABP placement. Inotropes were initiated and he was listed for heart transplantation on 8/16/23.

Pertinent past medical history includes Ewing sarcoma (diagnosed and treated at age 7 with Adriamycin), subsequent long standing nonischemic dilated cardiomyopathy (since approximately 1990), biopsy-proven cirrhosis, secondary pulmonary hypertension, pulmonary embolism (2/2023), restrictive lung disease, spontaneous pneumothoraces, chronic atrial fibrillation with prolonged pauses requiring permanent pacemaker placement with CRT-D upgrade (in the setting of tachy-brady syndrome and EF of approximately 36%), elevated parathyroid hormone, CKD, and anxiety.

Mr. Leopold's hospital course has been complicated by a left axillary balloon rupture on the evening of 8/16 with IABP replacement 8/17. On 8/19, Mr. Leopold developed a left-sided spontaneous pneumothorax for which the Interventional Pulmonology team placed a left-sided pigtail catheter (subsequently removed 8/22). On 8/23, the IABP

balloon ruptured (second time), with replacement in the cardiac cath lab the same day. His renal indices improved and stabilized and he continued to be UNOS status 2 listed for heart transplantation.

On 8/29/23, a suitable donor became available, and he proceeded to the operating room for orthotopic heart transplant with Dr. Villavicencio.

A suitable organ was procured for transplant on 8/29 and he proceeded to the OR with Dr. Villavicencio for heart transplantation.

Hospital Course
ICU: Mr. Noah Leopold arrived to the ICU following transplant cardiectomy and on Bi-VAD/ECMO support with an open chest. He was promptly re-listed for cardiac transplant. He returned to the OR on 8/31 for washout and chest closure. He returned to the ICU where sedation was stopped. He developed right upper extremity myoclonic movements and right deviated gaze which spontaneously resolved. Neurology was consulted to assess for seizure activity. While awaiting EEG monitoring his mean aterial pressure acutely dropped and the Bi-VAD's were unable to flow. He returned to the OR for reconfiguration of mechanical support. He returned to the ICU on VA ECMO. Chest tube output remained high and chest xray demonstrated right hemothorax, so his chest was subsequently washed out. Upon awakening, he was able to follow commands but demonstrated possible focal status epileptic activity in the form of right hand tremors. Neurology recommended continuing Keppra and propofol.

Renal function continued to decline and he required escalating doses of diuretics without improvement in urine output. Nephrology initiated continuous renal replacement therapy on 9/3. He developed rising lactatemia and a firm abdomen.

General Surgery performed an exploratory laparotomy on 9/6 with findings of 1 liter of ascites fluid with no evidence of bowel ischemia or bleeding. His abdomen was left open and covered with a wound vac. Due to coagulopathy he required the massive transfusion protocol following the procedure.

On 9/4, a second suitable donor was identified and he proceeded to the operating room for orthotopic heart re-transplant on 9/7 and arrived back to the unit on VA ECMO. His coagulopathy was treated with multiple blood products postoperatively.

On the morning of 9/8 his pupils were noted to be fixed and dilated prompting a head CT as well as Neurology and Neurosurgery consultations. Imaging showed extensive intracranial hemorrhage and diffuse cerebral edema. On neurologic exam he demonstrated no motor or brainstem reflexes despite being off sedation for several hours, raising concern for brain death. The Neurosurgery team determined there was no intervention, medical nor surgical, that would reverse the catastrophic intracranial sequelae. On 9/9 the multi-disciplinary team, lead by Neurosurgery conducted formal brain death testing. The multi-step exam and carbon dioxide testing confirmed brain death. Support was withdrawn and Noah Leopold was pronounced at 17:51 on 9/9/2023.

SURGICAL PROCEDURE(S)

Procedure Information: 8/30/23